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(m)(1) Readmission. A patient shall be defined as a readmitted patient (hereinafter "a readmission") for purposes of payment under the case based payment system when the patient is discharged from a nonexempt hospital and readmitted to the same nonexempt hospital within thirty-one (31) days of the original discharge for the same or a related condition for which the patient was treated at the time of the original discharge. The days between the original discharge and subsequent admission shall not be considered in the determination of payment pursuant to this subdivision.

(2)(i) The hospital shall receive a case based payment determined pursuant to the provisions of paragraph (4) of this subdivision for a readmission meeting the following criteria:

(a) the patient was a readmission and the appropriate payor determines pursuant to generally accepted standards of medical care that the readmission resulted from a premature discharge, or was for care which could have been provided during the first admission;

(b) the patient was admitted for surgery but surgery was delayed due to an operating room scheduling problem;

(c) a particular surgical team was not available during the first admission;

(d) a biopsy or other diagnostic procedure indicated the need for additional surgery which could have been performed during the first admission but was delayed until a second admission;

(e) the patient was admitted for surgery which had to be postponed because the patient had an infection or other medical problem which prevented surgery from being performed during the first admission;

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(f) any bilateral procedure requiring more than one admission except staged procedures as listed in subparagraph (ii) of paragraph (3) of this subdivision;

(g) the patient was admitted for elective surgery with an unstable medical problem which could be treated on an outpatient basis;[or,]

(h) there was a delay in obtaining a specific piece of equipment or device required for surgery [.] or

(i) the patient was a maternity patient who was readmitted for delivery of a baby within 24 hours of having been discharged.

(ii) the hospital shall have the right to request the payor to reconsider its determination under this subdivision and shall have the right to submit additional documentation in support of its position. Such request and additional documentation shall be submitted within 30 days of the original determination of the payor. The payor shall act upon such request for reconsideration within 45 days from receipt of the request and complete documentation.

(3) Notwithstanding the provisions of paragraph (2) of this subdivision, the hospital shall be eligible to receive a case based payment for each hospitalization if the hospital demonstrates that the readmission occurred under any of the following circumstances.

(i) the original discharge was a patient initiated discharge, i.e., the discharge was Against Medical Advice (AMA). The circumstances of such discharge and readmission shall be documented in the patient's medical record;

(ii) the readmission was for the following procedures and treatments that are performed in a staged manner:

First Admission	Followed by Readmission for
(a) Cardiac catherization (DRG 121, 122, 124, or 125)	Cardiac surgery, such as valve replacement or other cardiac procedures (DRG 105, 107 [~~,~~] or 108 [~~or 109~~])
(b) Aortogram (DRG 130 or 131) Resection (DRG 108, [~~109~~,] 110, 111 or 549)	
(c) Cerebral angiography (DRG 15)	Carotid endarterectomy (DRG 005 or 531) [~~108 or 112~~]
(d) Bowel resection (DRG 146, 147, 148 or 149) Closure of colostomy (DRG 152 or 153)	
(e) Cataract removal DRG 39).	Cataract removal (DRG 39)
(f) Mastectomy (DRG 257, 258, 259, 260 or 261). Mastectomy (DRG 257, 258, 259, 260 or 261)	
(g) Endarterectomy (ICD-9-CM procedure code 38.12) Endarterectomy (ICD-9-CM procedure code 38.12)	
(h) Chemotherapy (DRG 410)	Chemotherapy (DRG 410)
(i) Angiography (ICD-9-CM procedure codes 88.48, 88.49, 88.66 or 88.67)	Vascular Surgery (ICD-9-CM procedure codes 38.38, 38.49, 39.29, 39.49, 39.56 or 39.59)

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(j) Removal of infected AV fistula or bovine graft (ICD-9-CM Diagnosis Code 996.62, Procedure Codes 38.60 - 38.69)

Replacement of graft (ICD-9-CM procedure codes 39.56, 39.57 or 39.58)

(4) When the appropriate payor determines that a patient's readmission was for any of the reasons described in paragraph (2) of this subdivision, the hospital shall receive the lesser of: the total of the case based payments for the two separate admissions; or, the payment which would have been received pursuant to this Subpart by billing for a single case based payment by combining, according to the principal reason for patient admission, those diagnoses and procedures of the readmission with the diagnoses and procedures of the original admission, and total medically necessary days in the combined admissions.

(i) If the application of paragraph (4) of this subdivision results in the payment being the total of the case based payments for the two separate admissions, payment to the provider by the primary payor,

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secondary payor(s) or a patient assuming liability for coinsurance and deductibles shall be based on whether such payor was primary, secondary, or a patient assuming liability for coinsurance and deductibles at the time of the patient's discharge from the original admission except as described in paragraph (5) of this subdivision. The apportionment of the payment shall be determined in accordance with section 86-1.52(d) of this Subpart, applied to the total of the case based payments for the two separate admissions.

(ii)(a) If the application of paragraph (4) of this subdivision results in the payment being based on combining the readmission and the original admission into a single case based payment, payment to the provider by the primary payor, secondary payor(s) or a patient assuming liability for coinsurance and deductibles shall be based on whether such payor was primary, secondary, or a patient assuming liability for coinsurance and deductibles at the time of the patient's discharge from the original admission except as described in paragraph (5) of this subdivision.

(b) The apportionment of the payment shall be determined in accordance with section 86-1.52(d) of this Subpart, applied to the single case based payment, as follows: the dollar value of the percentage coinsurance covered by the patient or any supplemental insurer covering the patient's coinsurance percentage according to the terms of the patient's primary coverage shall be determined by multiplying the coinsurance percentage by the hospital's charges for the patient for the services covered by the primary payor, considering any deductibles. The hospital charges for this purpose shall mean the sum of the charges for the two separate admissions,

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subject to the maximum amount to be charged to any charge paying patient for a case pursuant to section 86-1.51(d)(1) of this Subpart, (applied to the single case based payment determined in paragraph (4) of this subdivision).

(5) If between the original discharge of the patient and the readmission of the patient, as defined in paragraph (1) of this subdivision, there is a change in the insurance carrier, self-insured group or other organization or entity having primary liability for the health insurance coverage of the patient, or if the patient was insured for the original admission but has no insurance or other coverage for the readmission, separate case based payments shall be made by the appropriate payors for each of the two admissions in accordance with section 86-1.51 of the Subpart.

Section 86-1.55 Development of Outlier Rates of Payment.

(a) Short Stay Outliers. Payments for short stay outlier days shall be made at a per diem calculated by multiplying the days of actual length of stay below the short stay threshold by the short stay per diem rates defined in this subdivision. The short stay per diem rate shall be determined by dividing the hospital's DRG case-based rate of payment determined pursuant to section 86-1.52(a)(1) by the hospital's group average arithmetic inlier LOS for the DRG and multiplying the result by the short stay adjustment factor of 150 percent. In cases where the group average arithmetic inlier length of stay for the DRG is equal to one, the short stay adjustment factor shall not be applied. Budgeted capital costs determined pursuant to section 86-1.59 of this Subpart shall be added to the per diem.

(b) Long stay outliers. Payments for long stay outlier days shall be made at a per diem rate calculated by multiplying the days of the actual length of stay in excess of the long stay outlier threshold by 60 percent of the per diem obtained by dividing the group average DRG operating cost per discharge defined in section 86-1.54 (b) of this Subpart by the hospital's group average arithmetic inlier length of stay for the DRG. This result shall be multiplied by the percent for the group average reimbursable inpatient operating cost determined pursuant to section 86-1.53 of this Subpart. These payments shall include a [~~primary~~] health care services allowance of [~~.23 percent~~] .614 percent for rate year 1994 and .637 percent of rate year 1995 of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(c) Cost outliers. (1) Cost outlier payments must be requested from the third-party payor.

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(2) Cost outlier payments shall be determined by reducing total billed patient charges to cost (based on the hospital's 1988 ratio of cost to charges using 1986 data until 1988 data becomes available) and shall equal one hundred percent, multiplied by the reduction factor, if any, developed pursuant to paragraph (3) of subdivision (f) of section

86-1.54, of the difference between such cost, and the greater of two times the hospital's diagnosis related group case-based rate of payment for the patient as calculated pursuant to paragraphs (a)(1)-(2) of section 86-1.52 of this Subpart, subsequent to the elimination of all prospective adjustments which reflect a retroactive impact of an adjustment in accordance with section 86-1.61(l) of this Subpart or six times the hospital's average DRG case-based rate of payment for the patient as calculated pursuant to paragraphs (a)(1) and (2) of section 86-1.52 of this Subpart, subsequent to the elimination of all prospective adjustments which reflect a retroactive impact of an adjustment in accordance with section 86-1.61(l) of this Subpart.

(3) Cost outlier payments shall not be made for cases that qualify as short stay outliers or transfers (other than patients assigned to transfer DRGs). Patients assigned to transfer DRGs may meet the criteria for outlier payments, in which case the limitations set forth in this paragraph shall apply. If during a rate year the payments for high-cost patients made pursuant to this subdivision reach the proportion of high costs calculated pursuant to section 86-1.54(f)(3) of this Subpart, then all additional requested high-cost payments for that rate year, including the inlier DRG case payment rate, shall be pended until the appropriateness of the charge schedule upon which the high costs are determined is reviewed.

(4) A [~~primary~~] health care services allowance of [~~.23 percent~~] .614 percent for rate year 1994 and .637 percent for rate year 1995 of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58 shall be added to the cost outlier payments.

(5) Hospitals that have not established ancillary and routine charges schedules shall not be eligible for high-cost outlier payments.